

Medical Tribune Reports

Pastoral Passivity

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Wednesday, November 20, 1974

Medical Tribune Review

By NATHAN HORWITZ

"Our patients are altogether correct."
Continued on page 13

Medical Tribune Report

BY FRANCES GOODNIGHT
Medical Tribune Staff

Continued on page 10

Early Neonatal Meningitis Is Linked to Low Birth Weight

Medical Tribune World Service

TORONTO—All but 5 per cent of cases of early-onset neonatal meningitis are related to low birth weight or prematurity, Dr. Fred F. Barrett, Associate Professor of Pediatrics at Baylor College of Medicine, said here at an international Symposium on Infections in the Fetus and Newborn, sponsored by the Canadian Pediatric Society.

Streptococcal B infections are a significant new problem for neonates, he said, noting that such infections now cause about 65 per cent of all neonatal meningitis, compared with 33 per cent in 1970.

"It may have been a problem in earlier years but we didn't recognize it," he remarked.

Dr. Barrett, deputy director of the infectious diseases program at the Texas Children's Hospital, Houston, spoke on "Changing Patterns of Bacterial Infections."

Would Focus on Risk Factors

Referring to the association of birth weight and prematurity with meningitis, he said: "We have to focus down on these risk factors. The mothers in this risk group should be watched carefully and a certain number should be treated expectantly. I wouldn't call this prophylaxis, I'd call it early treatment."

Early-onset meningitis, symptoms appearing after five days, results in a mortality of 60-75 per cent, whereas

late-onset disease, symptoms after 10 days, results in 14-18 per cent, Dr. Barrett said.

In contrast to the high correlation between the early-onset disease and obstetrical complications, only 19 per cent of the late-onset cases showed such difficulties, he noted.

Of patients with early onset, 86 per cent had positive signs of streptococcal infection, while 14 per cent were heavily colonized early in life, he said.

"The organisms isolated from multiple sites suggested that the early-onset disease was acquired in utero or from the mother at time of delivery," Dr. Barrett said. "The mortality is high because probably many are infected in utero. These infants are sicker for a

longer time than their age indicates. We must recognize the risk patients earlier than we do now and treat them earlier, and recognize the risk mothers and treat them earlier."

Of 200 mothers randomly selected at term, he reported, 25 per cent were colonized at one or more sites, and 25 per cent of the offspring were colonized. Obstetrical difficulties are not related to the risk of colonization.

Symptoms of early-onset disease are unexplained episodes of apnea and high frequency of seizures, whereas in

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PSRO Program Moving on Time As Foes Retreat

Continued from page 1

that, he declared, had been occurring last year. "Already there are 115 PSRO's under development, 10 are actually reviewing cases, and by the next funding cycle, we expect to see another 40 or 50 PSRO's, or about 150 by next year."

He told a news conference that some state-wide medical groups that had been most outspoken against the PSRO proposals have become more muted, since the A.M.A.'s House of Delegates last June called for détente with PSRO.

"When I go back to private practice, I hope to see a PSRO in my area," he stated. "It's the best protection I have."

A leading surgeon told the newsmen that further debate on the law is "an exercise in futility." Dr. George R. Dunlop of Worcester, Mass., vice-chairman of the A.C.S. Board of Regents, declared: "The PSRO law is a fact of life, it's the law of the land. Let's not waste energies debating its merits or how it came about."

He said there has been less opposition to PSRO among surgeons than among some other specialties, because "surgeons are traditionally accustomed to working in an environment where they are scrutinized by their colleagues; they are accustomed to peer review and to retrospective analysis."

He added: "By and large those segments of the profession who are accustomed to working in this environment feel a little more secure with PSRO. That segment of the profession not accustomed to working in this environment feels less secure, more hostile. When they find what is entailed, they'll feel less threatened." —N.H.

Shriver Bids AMA Yield Spokesman Role to APHA

Medical Tribune Report

NEW ORLEANS—The American Medical Association should relinquish its role as the spokesman for the nation's physicians, according to Sargent Shriver, the original director of the Office of Economic Opportunity.

"I would like to suggest that the American Public Health Association become the voice of American medicine instead of the A.M.A.," he told the A.P.H.A.'s annual meeting.

Wednesday, November 20, 1974

'Structured' Counselor Role With Married Patients Urged

Medical Tribune Report

LOS ANGELES—The family physician should play a "well structured role" of marriage counselor for his patients—according to the point of recommending divorce at times, Dr. Beverley T. Mead told the 26th Annual Scientific Assembly of the American Academy of Physicians in Los Angeles.

"You should step in with specific advice when it is needed rather than wasting time with the slow-paced indirect approach favored by some psychiatrists," said Dr. Mead, Professor and head of the Department of Psychiatry at Creighton University School of Medicine in Omaha. The more structured approach taken by the family physician, he said should involve prevention of marital troubles before they occur as well as counseling those patients who already have difficulties.

"In some cases when you find that divorce is the best answer to well-

established problems you should tell your patients so," he suggested. "It may be true that a child suffers in a broken home, but he or she may suffer more in a home that should be broken."

However, if one partner wants a divorce and the other does not, it is often possible to restore the union by convincing the negative one to stick it out a little longer. "If they struggled along for six years, with a better understanding of their problems, they should do themselves the favor of seeing whether or not they can struggle successfully through another three weeks," Dr. Mead said.

The Nebraska psychiatrist also told the A.A.P. that family physicians should play a role in discouraging marriages when the couple is obviously poorly prepared or mismatched. He recommended especially against teenage marriages.

MEDICAL TRIBUNE



DR. BEVERLEY T. MEAD

"Marriage is for grownups. If I could do it, I'd support legislation against marriage before the age of 21."

In their pre-marriage counseling, family physicians should probe their patients' attitudes on many fronts, in-

Continued on page 13

Small Vitamin C Doses 'Just as Good' in Colds

Medical Tribune Staff

NEW YORK—The newest findings in large-scale Canadian trials of vitamin C suggest that ascorbic acid prevents or reduces the symptoms of colds in far smaller doses than have been recommended.

Dr. Terence W. Anderson, Professor of Epidemiology and Biometrics at the University of Toronto, reported that a double-blind study of 600 healthy volunteers—the latest in three trials with a cumulative total of nearly 5,000 subjects—has shown that "relatively modest" intake of vitamin C "may be sufficient to produce a useful reduction in over-all morbidity [of colds]."

"Tissue saturation is apparently achieved with 100 mg. of ascorbic acid daily, and there appears to be no benefit in dosages above that," he declared, noting that results of the last trial were approximately the same as those of the two earlier ones, with 30 per cent fewer days of absence from work or spent indoors among the vitamin group as compared with placebo subjects.

Dr. Anderson spoke at an international conference on vitamin C jointly sponsored by the New York Academy of Sciences and the Institute of Human Nutrition at Columbia University.

In the latest study, he said, the volunteers received a prophylactic ascorbic acid dose of 500 mg. weekly in a sustained-release form during the three-month trial. The dosage was increased to 500 mg. daily on the first day of illness, and continued if needed at 12-hour intervals for the next four days. These schedules were in marked contrast to prophylactic and therapeutic doses ranging as high as 4 Gm. daily in the two earlier trials, Dr. Anderson reported.

All three trials, he continued, now have shown "a small vitamin effect on the number of [cold] episodes per subject, but a more substantial effect on the days indoors or off work. Similarly, all have shown consistently little or no effect on days of nasal symptoms (thus casting some doubt on the antibacterial theory of vitamin C action), while

there have been some large but inconsistent effects on days of chest symptoms, fever, and malaise."

"The benefits occurring regardless of the dose employed, he added, suggest that the dosages used in the team's first trial were "probably unnecessarily high."

In commenting on the group's overall experience, Dr. Anderson observed that a "host of secondary questions" presented themselves as evidence began to accumulate in the first two trials suggesting that Vitamin C does exert "some sort of effect." Of these questions, the most important was, "If large doses are necessary does the risk of side effects outweigh the possible benefits? It was largely in order to resolve this and related problems that the third trial was undertaken."

No Toxicity Observed

Dr. Anderson stressed that he and his team have seen no symptomatic evidence of toxicity resulting from doses of 2,000 mg. daily over three or four months in healthy persons, but "this does not mean that this dose level is necessarily safe for longer periods, particularly in individuals with pre-existing disease, or that the occasional individual might not show some unusual and undesirable reaction."

He also warned: "While perhaps not a side effect in the ordinary sense of the word, the depression in blood ascorbic levels that occurs on sudden withdrawal of a chronic high intake should be recognized as a potentially harmful reaction. For example, an individual admitted to a hospital with an acute medical or surgical condition might be at a physiological disadvantage if this period of unusual stress coincided with the withdrawal of a regular high intake."

He concluded that "unless and until firm evidence is forthcoming that higher doses of vitamin C are more effective, we should adhere to the principle of *primum non nocere* and advise the public to limit their daily

intake to 100 or 200 mg. except possibly for brief periods during acute infection when gram doses may be beneficial."

At a press conference, Dr. Anderson emphasized that "it is quite possible" that the beneficial effects observed during the trials were not more than symptomatic. "We were only recording symptoms as reported by the subjects," he said. "We didn't have the facilities for serologic or virologic studies."

Two leading investigators at the press conference joined in calling for moderation in the use of ascorbic acid. Dr. Myron Wajick, director of Columbia's Institute of Human Nutrition, declared: "When people talk about giving vitamin C in doses of 10 Gm. a day, they're talking about quantities in the category of therapeutic agents. I would not want to see vitamin C on the market as a therapeutic agent until its safety in that range is appropriately demonstrated."

Alfred E. Harper, Ph.D., of the University of Wisconsin, also cautioned against using vitamin C "as a drug to treat conditions that are not caused by the absence of the compound as a result of nutritional deficiencies."

Dr. Harper, who is former chairman of the Committee on Dietary Allowances of the National Nutrition Council/National Academy of Sciences, said, "We have to separate the nutritional and therapeutic uses of nutrients and see how they compare with other drugs used to treat the same disorders."

ECTOPIC BEAT

"It isn't absolutely necessary for executives to have heart disease, ulcers and stroke, ailments commonly associated with American businessmen who reach the management level."

—News release from the A.M.A. But it's still kind of *de rigueur* isn't it?

(Regular beat: *Immature Medicine*, page 23.)

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CLINICAL NEWS NOTE: "Using this technique, we have noted our patients are less anxious when biopsy is recommended, because they are sure of a minimal operation, with a short hospital stay. No patient, subsequently discovered to have benign [breast] disease, has been sorry she underwent the operation, since no disfigurement has resulted. Patient acceptance has been universally excellent." (Dr. Gordon F. Schwartz, see pg. 1.)

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Medical Tribune

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Enzymes Help Differentiate Infarction, Gauge Infarct Size

Medical Tribune World Service

BUENOS AIRES—The detection in serum of one enzyme (glycogen phosphorylase *b*) can help differentiate myocardial infarction from noncardiac myopathies. Serial determinations of another enzyme (creatine phosphokinase) are a "valuable method for intravital estimation of infarct size."

Separate research teams presented these two conclusions to the Seventh World Congress of Cardiology here.

Glycogen phosphorylase *b* is absent or undetectable in the serum until about two hours after the onset of myocardial infarction, and the level peaks about 24 hours after infarction, reported Drs. A. Wollenberger, M. Böhm, E. G. Krause, and H. Will, of the Central Institute of Heart and Circulatory Regulation Research, Academy of Sciences of the East German Democratic Republic, Berlin-Buch.

The only disorders other than myocardial infarction that have previously been shown to produce detectable serum levels of phosphorylase *b* are encephalomalacia and noncardiac myopathies, including dermatomyositis and dystrophy, according to these investigators.

Differentiating Infarction

"The heart-specific striated muscle phosphorylase *b* isoenzyme can be separated from other muscle isoenzymes by acrylamide gel electrophoresis," Dr. Wollenberger explained, "thus permitting the differentiation of myocardial infarction from noncardiac myopathies."

Serum levels of phosphorylase *b* in seven patients who died between the first and fourth day after myocardial infarction were compared with those of 51 patients who survived infarction. Blood samples were taken between 20 and 30 hours after infarction.

"Patients who did not survive had much higher serum phosphorylase *b* levels than those who survived," Dr.

Wollenberger said. "Thus, the determination of serum phosphorylase *b* may have prognostic value in myocardial infarction."

Serial Determinations of CPK Indicate Size of Infarct

Infarct size was calculated in 32 patients with acute myocardial infarction by serial determinations of CPK, reported Drs. W. Bleifeld, D. Mathy, and P. Haarath, of the Department of Internal Medicine, Rheinisch-Westfälische Technische Hochschule, Aachen, West Germany.

They determined CPK concentration every two hours after the infarction for the first 20 hours, and then every four hours, and these data were re-

lated to hemodynamic data. In 10 human hearts, infarct size was measured post mortem and correlated to infarct size as calculated from serial determinations of CPK.

There was an "excellent correlation" between calculated infarct size and infarct size as determined at autopsy, Dr. Bleifeld said. Infarct size correlated well with the deterioration of hemodynamics, and he blamed "differences in this relation" on previous lesions of the left ventricle.

In 25 patients who were suffering from their first myocardial infarction, mean left-ventricular necrosis was 66 Gm., pulmonary end-diastolic pressure increased to 20 mm. Hg, and cardiac index decreased to 2.9 L./minute/M.²

The remaining seven patients who had previous myocardial infarctions had a "relatively small" infarct size (mean 38 Gm.), but a "markedly increased" pulmonary end-diastolic pressure of 23 mm. Hg, and a reduced cardiac index of 2.5 L./minute/M.²

Aid to Prognosis and Therapy

"In conjunction with hemodynamic data," Dr. Bleifeld said, "evaluation of infarct size reveals a better understanding of the functional state of the heart, the prognosis and therapeutic interventions."

The mass and the functional state of the residual myocardium, rather than the size of the acute infarct itself, determines pump function, he said.

Margaret's contribution to gonorrhea:

The genealogy of an epidemic.



Current Opinion

Heavy Drinking, Smoking, and Cancer

By MARK KELLER

Research Specialist in Documentation
Center of Alcohol Studies, Rutgers University,
Piscataway, N.J.
National Institute on Alcohol Abuse and Alcoholism

IN THE ARTICLE by Nathan Horwitz (MT, Aug. 14) three experts are cited as asking for clarification of the statement by Dr. Morris E. Chafetz, Director of the National Institute on Alcohol Abuse and Alcoholism, that "the combination of heavy drinking and smoking increased by 15-fold the risk of mouth and throat cancer."

The statement is based on the review of the subject in Chapter V, Part 1, of the *Second Special Report to the U.S. Congress on Alcohol and Health*, prepared by a Task Force under Dr. Chafetz's chairmanship and published under my editorship. The particular statement is referenced to the study by

Drs. Kenneth Rothman and Andrew Keller, in the *J. Chronic Dis.*, 25: 711-716, 1972.

Their Table 2 (p. 713) shows that, with the risk of oral cancer for people who neither smoke nor drink set at 1, the risk for those who are both heaviest drinkers and heaviest smokers is

15.50. That finding was based on a sophisticated regression analysis of 483 cancer patients and a matched control group of 447 people, all patients in three VA hospitals in New York City, from whom adequate drinking and smoking histories were obtained. In addition, the *Report* cites several other studies which show a decided increase of relative risk of oral cancer from combined heavy smoking and heavy drinking.

Horwitz's article quotes the three authorities also to the effect that they have had great difficulty in gathering enough cases of heavy-drinking nonsmokers to establish the relative risk of heavy alcohol consumption alone. This problem is recognized and emphasized in the *Report*. But it was overcome at least in the recent study by Drs. Rothman and Keller who, in

their Table 2, show also that with the risk of oral cancer set at 1 for non-drinking nonsmokers, the risk for heavy smokers who do not drink is 2.43, and the risk for heavy drinkers who do not smoke is practically identical, 2.33. These statistics formed the basis for Dr. Chafetz's statement of an increased risk from heavy alcohol consumption alone.

Many experts were unconvinced by the Surgeon General's original announcement of increased risk from cigarette smoking, which aroused worldwide debate. Nevertheless it was the duty of the Surgeon General to make the information he had available to the American public and to the physicians who advise them about their health. It was likewise the duty of the Director of the National Institute on Alcohol Abuse and Alcoholism to share the information available to him. This has been done in great detail with full documentation in the *Second Report to Congress on Alcohol and Health*, freely available from NIAAA (5600 Fishers Lane, Rockville, Md. 20852).

The three authorities interviewed by Horwitz rightly urged the need for more research. The *Report* not only discusses the cautions appropriate for interpreting the existing data but likewise emphasizes the need for more research. The National Institute is indeed fostering such additional research, among others by the World Health Organization's International Agency for Research on Cancer, and in due course will make the results known to the health professions and the American public.

The one disturbing feature in Horwitz's article is the quotation of Dr. Ernest P. Wynder to the effect that "Heavy drinking by itself does not increase the risk of cancer . . . in the absence of smoking." It is not understandable how Dr. Wynder can be so positive. If his samples contained too few nonalcohol heavy drinkers to conclude there is an increased risk, then obviously there were too few to conclude there is no increased risk, and the most he could say is that his evidence is inconclusive.

Ten papers by Dr. Wynder and his associates are cited in the *Report*, dated between 1956 and 1972. In one (*Cancer*, 10: 1300-1323, 1957) they say (p. 1306), "In our data two factors, alcohol and tobacco, seem to increase the risk of oral cancer when each is considered separately," but in none of them is there any evidence that "Heavy drinking by itself does not increase the risk of cancer." I would hate to be the author of such a guarantee, even if it did not go against the demonstration of the opposite by Rothman and Keller. Since the statement can be harmfully misleading, I am sure MEDICAL TRIBUNE will want to set the record straight.

The *Report*, and Dr. Chafetz's statement, did not implicate moderate drinking, nor was it suggested that alcohol can cause cancer. The explicit emphasis was the increased risk from heavy drinking, and the added or synergistic risk from combined heavy drinking and smoking. We all need to think about the first risk as well as the second, even while waiting the years it may take for the desirable additional research to be completed.

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Animal studies indicate that tetracyclines cross the placenta, are found in fetal tissues and can have toxic effects on the developing fetus. Evidence of embryotoxicity has also been noted in animals treated early in pregnancy. Tetracyclines are present in the milk of lactating women who are taking a drug in this class.

Precautions: Overgrowth of nonsusceptible organisms may occur, including fungi. If such superinfections are encountered, discontinue Vibramycin and institute appropriate therapy. In venereal disease when coexistent syphilis is suspected, a dark-field examination should be done before initiating therapy. Conduct monthly serological tests for at least 4 months.

Because tetracyclines depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment in their anticoagulant dosage.

In long-term therapy, conduct periodic laboratory evaluation of organ systems, including hematopoietic, renal and hepatic. Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. (For upper respiratory infections due to Group A beta-hemolytic streptococci, penicillin is the usual drug of choice, including prophylaxis of rheumatic fever.)

Avoid giving doxycycline with penicillin because of possible interference with penicillin activity.

Adverse Reactions: Anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the oropharyngeal region, maculopapular and erythematous rashes, exfoliative dermatitis, photosensitivity, urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus, hemolytic anemia, thrombocytopenia, neutropenia and eosinophilia have been reported. Prolonged administration of tetracyclines may produce brown-black microscopic discoloration of thyroid glands. No abnormalities of thyroid function studies are known to occur. Bulging fontanels have been reported in young infants on therapeutic dosage but disappeared when the drug was discontinued. A dose-related rise in BUN has been reported.

Adult Dosage: DOSAGE AND FREQUENCY OF ADMINISTRATION OF DOXYCYCLINE DIFFERS FROM THAT OF OTHER TETRACYCLINES. EXCEEDING RECOMMENDED DOSEAGE MAY PRODUCE INCREASED INCIDENCE OF SIDE EFFECTS. The usual dose of Vibramycin is 200 mg. on the first day (administered 100 mg. every 12 hours) followed by a maintenance dose of 100 mg./100 mg. every 12 hours. In more severe infections (particularly chronic infections of the urinary tract), 100 mg. every 12 hours is recommended. See package insert for recommended dosage schedules for children.

When used in streptococcal infections, therapy should be continued for 10 days. Acute gonococcal infections: 200 mg. stat, and 100 mg. at bedtime, the first day, followed by 100 mg. b.i.d. for 3 days. As an alternate single-visit dose, administer 300 mg. stat followed in one hour by a second 300-mg. dose. The dose may be administered with food, including milk or carbonated beverages, as required.

Primary and secondary syphilis: 300 mg. a day in divided doses for at least 10 days. If gastric irritation occurs, it is recommended that Vibramycin be given with food or milk. The absorption of Vibramycin is not markedly influenced by simultaneous ingestion of food or milk. Antacids containing aluminum, calcium, or magnesium impair absorption and should not be given concomitantly to patients taking oral Vibramycin.

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cal management. Furthermore, intense anxiety can interfere with patient cooperation in following your therapeutic directives. When counseling and reassurance alone are inadequate to relieve undue anxiety, adjunctive Librium (chlordiazepoxide HCl) may be beneficial.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discon-

tinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimula-

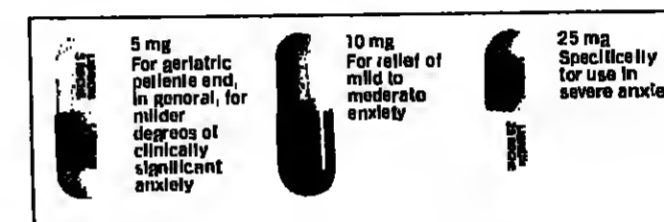
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Librium is used concomi-

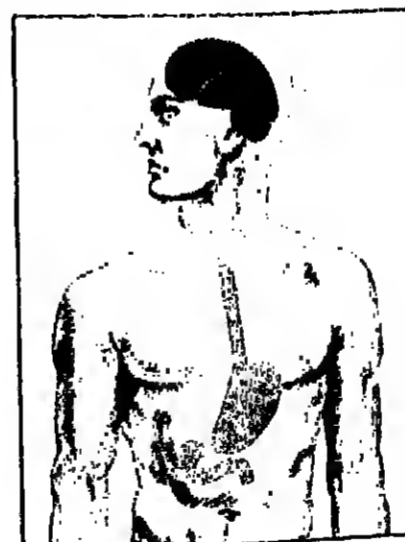
tantly with certain specific medications of other classes of drugs, such as anticholinergics and antacids. After anxiety has been reduced to tolerable levels, Librium (chlordiazepoxide HCl) therapy should be discontinued.



For relief of excessive anxiety
adjunctive

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1 or 2 capsules t.i.d./q.i.d.

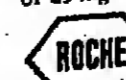


tion and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual

irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Embolization Curbs Upper Gastric Bleeding

Medical Tribune Report

SAN FRANCISCO—Selective embolization of the left gastric artery controlled upper gastric bleeding in eight of 11 patients, demonstrating that the technique is a feasible alternative to arterial vasopressin infusion, according to a Michigan study.

Dr. Vincent P. Chuang of Ann Arbor reported at the American Roentgen Ray Society meeting here that embolization appears to offer two advantages.

The technique, in which the left gastric artery is embolized with aminocaproic acid-mixed autogenous blood clot, autogenous fat globules, sterile oxidized cellulose, or absorbable gelatin sponge, is simple and results are immediate, he said.

And he emphasized that since the patient is not given large doses of vasoconstricting drugs, no monitoring is required for side effects.

Dr. Chuang said that while further experience is needed, preliminary results are promising. Ten of the 11 patients treated with the technique at the Wayne County General Hospital were terminal bleeders in whom heart, lung, renal, or liver complications precluded surgery, he related.

Success Rate 70%

The success rate in this group was 70 per cent and would probably have been higher if the patients had not been terminal bleeders, he said.

Seven of the patients in whom the technique was successful are alive and

well two to 14 months after the procedure, with no recurrence of bleeding, Dr. Chuang reported. The eighth patient died of pneumonia unrelated to the gastric bleeding 11 months after embolization and with no evidence of further bleeding, he added.

Of the three failures, two patients had diffuse hemorrhagic gastric bleeding and died of complications and one had a large gastric ulcer, he said.

The gastric mucosa was observed in six of the patients one to five days after embolization, he continued. Five showed no evidence of mucosal necrosis and one showed scattered areas of mucosal slough.

Dr. Chuang noted that vasopressin infusion is indicated in patients with gastritis.

The overweight diabetic... trapped by her own fat cells.

If only she would diet, her blood sugar might come down. Her high levels of blood insulin might come down, too. This may be important in the overweight diabetic since insulin is the "storage hormone" that transports glucose into adipose tissue. Maybe the last thing the overweight diabetic needs to lower her blood sugar is a drug that stimulates more insulin secretion.

If dieting doesn't work in the overweight, nonketotic, adult-onset diabetic, consider adding DBI-TD.

DBI-TD® Geigy phenformin HCl

Lowers blood sugar without raising blood insulin.



DBI-TD® phenformin HCl Tablets of 25 mg.
DBI-TD® phenformin HCl
Time-release capsules of 50 and 100 mg.

Indications: Stable adult diabetes mellitus, particularly in the primary and secondary, not yet insulin-dependent, or unstable diabetes mellitus. **Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus; that is accompanied by well-regulated insulin-dependent diabetes mellitus; or that is accompanied by severe complications of diabetes mellitus (myocardial infarction, stroke, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after severe states associated with hypotension. **Warnings:** The drug should be used with caution in patients with hypotension. **Precautions:** 1. Starvation ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy; excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. Do not give insulin without first checking blood and urine sugar. 2. Lactic Acidosis: This drug is not recommended in the presence of acidosis or in any clinical situation that predisposes to sustained hyperventilation that could lead to lactic acidosis. To differentiate lactic acidosis from ketonuria, periodic determination of ketones in the blood and urine should be made in diabetic patients stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis. 3. Hypoglycemia: Although hypoglycemia is

addition to two when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin. **Adverse Reactions:** Principally gastrointestinal: unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (DBI 148-103-2 (N72))

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10509

Learn Self-Examination



Many hospitals, like New York City's Lenox Hill (above), have started classes to teach women how to examine themselves for signs of breast cancer because of the increased demand for information following the recent operations on Betty Ford and Happy Rockefeller.

Radon Seeds Put Eye Melanoma Under Control

Medical Tribune Report

SAN FRANCISCO—Local irradiation with radon seeds can provide local control of malignant melanoma of the eye in a majority of patients, an Ohio State study has indicated.

Dr. Gunther Ehlers reported to the American Roentgen Ray Society that the technique, in which a ring applicator 2 mm. larger than the tumor and filled with radon seeds for a dose of 6,000-9,000 roentgens is implanted in the affected eye, has provided local control in 61 per cent of the patients evaluated.

In these patients, enucleation was avoided, vision saved, and metastases apparently prevented, he said.

He reported on 18 patients. In seven the technique was not successful and enucleation was performed in six.

Enucleation Often Falls

Dr. Ehlers noted that enucleation frequently fails to cure primary malignant ocular melanoma and approximately half the patients succumb to metastatic disease.

He suggested that the more conservative approach with local irradiation might be used for selected patients. The failures of this technique appeared to be related more to the size of the tumor than the dose, he remarked, adding that the technique was most effective with tumors between 5 and 10 mm. in diameter.

The implanted ring is left in place indefinitely. Complications have been seen in half the patients, but have seldom been severe and have resolved spontaneously. Patients are being followed carefully to be sure no long-term complications develop. Dr. Ehlers added.

One Man...and Medicine

ARTHUR M. SACKLER, M.D.,
International Publisher, Medical Tribune



Thirty-Dollar Steaks?

I DON'T BELIEVE the full implication of inflation has yet hit home to the American people. Most of our patients see it as a reduction in salary, an inconvenience, albeit outrageous. I wonder if our people completely understand its potential impact on our national health. Of course, medicine in this country has played a great role in reducing infant mortality (not yet enough), in increasing longevity (not yet enough), and in raising the standards of health (not yet enough). But has not the real substrate for most of our health advances been improvements in nutrition, in housing, in working conditions, as well as in a few basic public health measures?

During the summer we laboriously tracked down the most recent official Bureau of Labor price statistics giving national average prices on some important foods during July, 1974—and July, 1973. They are based on a sample of 39 metropolitan areas and 17 smaller cities. I publish them in the box below—so that you can go shopping and make your own comparisons. For since then prices have soared, making these figures completely out-of-date.

Latest Figures

According to the Labor Department's Consumer Price Index, by October prices had made their biggest jump since 1947. The increase in all consumer prices was 12.1 for the year—and for food alone was 11.3 per cent. In September the biggest increases were meat, fish and poultry—up 3.2 per cent that month.

I am told that steak is going for \$5 a pound in some neighborhoods. Who ever heard of fish selling at nearly two

Overcoming the Damage

I can understand why the indignation of our people focuses on the economics instead of the health aspects of spiraling food costs. It is more immediately visible. Have a pill damage a score of people, and a hysterical flurry of action ensues—hearings and headlines, legislation and regulation. Have scores of thousands of pregnant women malnourished and their children severely damaged in utero by lack of food—and there ensues a resounding silence.

This makes no sense. Remember the wartime days when our Government stressed the seven basic foods?

1. Leafy green and yellow vegetables.
2. Citrus fruits, tomatoes, raw cabbage.
3. Potatoes, other vegetables and fruit.
4. Milk, cheese, ice cream.
5. Meat, poultry, fish, eggs, dried peas and beans.
6. Bread, flour, cereals.
7. Butter and fortified margarine.

And what if one were to try to follow this advice today?

Eat green vegetables every day. How many middle- and low-income large-alized families can eat green salads every day at present costs?

Be sure to drink orange juice every day. This absolutely essential source of ascorbic acid has gone from 25¢ for 10 oranges in 1940 to 93¢ for 10 oranges in 1974. However, if 10 oranges pro-

vide a quart of orange juice and 6 ounces of orange juice provides approximately 90 mg. of ascorbic acid, one could get almost 500 mg. of vitamin C by consuming the whole quart—which currently costs 79¢. This compares with a 500-mg. tablet of ascorbic acid costing anywhere from 1¢ to 4¢ per tablet.

Be sure to have bread and milk every day. I can hardly believe that the white "sponge" on the grocery shelves is now over 50¢ a loaf, and milk 43¢ a quart. Have some meat each day. Are you kidding?

It is high time for the American physician and organized medicine and all our patients to make crystal clear to our Government that inflation is not just a pocketbook issue but for many a matter of health or illness and, for some, ultimately life and death.

It is a farce to hold hearings on the cost of health care, on the treatment of disease, rather than on the health threat of food inflation. It is like locking the barn door after the horse has been stolen. The most important type of medicine is preventive, and one of the most important preventive medicines of all is an adequate, well-balanced diet.

EPIGRAMS—Clinical and Otherwise

We all labor against our own cure,
for death is the cure of all diseases.
St. Thomas Browne (1605-82)
Religio Medici

Early Neonatal Meningitis Linked to Low Birth Weight

Continued from page 2

late-onset, lethargy and fever appear and there are fewer episodes of apnea and symptoms characteristic of meningitis in older patients.

Asked when to start antibiotics and how long to continue, Dr. Barrett said that the answers depend largely on subsequent developments and on the time it takes for the physician to get reliable information from the laboratory.

"We can rely on a negative culture report after five days, so we continue the antibiotic for five days and if the signs are negative we discontinue, but we have no hard and fast rule on that," he explained.

Antimicrobial Therapy

Dr. Jerome O. Klein, Associate Professor of Pediatrics at Harvard University, described gentamicin and kanamycin, along with a penicillin, are the drugs of choice in treating early-onset neonatal meningitis.

Chloramphenicol is useful against gentamicin-resistant strains, he said. Polymyxin B should not be used for neonatal infections as it does not cross biological membranes into body fluids, he said, the only exception being when it can come in direct contact with the organisms.

In late-onset meningitis, Dr. Klein said, penicillin is the drug of choice for streptococcal infections and gentamicin against any atypical bacterial organisms.

Before antimicrobial therapy begins,

cultures must be taken of the blood, spinal fluid, and urinary tract, he stated.

Communication with the obstetrician is critical in neonatal infections, Dr. Klein went on.

"When there is rupture of the maternal membranes, any infant exposed in the birth canal for more than 24 hours is an infant at risk," he said.

Signs of these infections are often subtle, he observed, but among specific signs to watch for are jaundice, poor feeding, and lethargy. The white count is not helpful in diagnosis, he noted. Any infant with unexplained fever must be considered at risk.

The umbilical cord should be carefully checked for any inflammation, joints manipulated to see if there is an early onslaught of arthritis, and a check made for urinary tract infection or peritonitis, Dr. Klein said.

Recently, he said, infants with otitis have been encountered, and this is a new cause of concern.

"It is not easy to examine tympanic membranes, but it can be done with training, and this is also a good region for aspiration," he commented.

There are considerable limitations in looking at the level of immunoglobulin as a sign of neonatal sepsis, he observed, as increased levels of IgM are present in noninfected infants, and some infected infants have not had elevated levels. A more promising line of investigation, he added, is that specific antigens will be found as an indication of infection.

Medicine on Stamp

Philbert Commerson



Philbert Commerson (1727-73) received his medical education at Montpellier. After graduating with an M.D. he devoted his full time to natural sciences. He sailed with Louis Bougainville on an expedition around the world, making drawings and collecting specimens. Settling in Mauritius, he classified the flora and fauna. Stamp issued in 1974.

Text: Dr. Joseph Kler
Stamp: Manus Publications, Inc., New York

Sitting pretty for years to come...

Gentle in bringing patients down to normotensive levels, Esidrix will continue to "sit right" with many of the mild hypertensives for whom you prescribe it. Indeed it can mean years and years of even, uneventful control.

Esidrix. It is still unsurpassed as a basic diuretic/anti-hypertensive. And many patients with edema rarely need a more potent diuretic.

Contraindications include anuria. Use cautiously in patients with impaired renal or hepatic function.

Esidrix® (hydrochlorothiazide) for year-after-year control of mild hypertension



Esidrix® (hydrochlorothiazide)

INDICATIONS

Hypertension and edema.

CONTRAINDICATIONS

Anuria; hypersensitivity to this or other sulfonamide-derived drugs. The routine use of diuretics in an otherwise healthy pregnant woman with or without mild edema is contraindicated and possibly hazardous.

WARNINGS

Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Thiazides may be additive or potentiative of the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions are more likely to occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy: Usage of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides cross the placental barrier and appear in cord blood and breast milk.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. Observe patients for clinical signs of fluid or electrolyte imbalance (hypotension, hypochloremic alkalosis, and hypokalemia). Serum and urine electrolyte levels are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs are dryness of mouth, thirst, weakness, lethargy, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea or vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially during brisk diuresis. When severe cirrhosis is present, or during concomitant administration of diuretics or ACTH, interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in hypernatremia or renal disease). Dilutional hyponatremia may occur in susceptible patients in hot weather; appropriate therapy is water restriction rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Transient elevations in plasma calcium may occur in patients receiving thiazides, particularly in those with hyperparathyroidism. Pathological changes in the parathyroid gland have been reported in a few patients on prolonged thiazide therapy.

Hypertension may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes may become manifest during thiazide administration. Thiazide drugs may increase the responsiveness to tubocurarine. The antihypertensive effects of the drug may be enhanced in the post-sympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

Thiazides may decrease serum PBI levels without therapeutic use. If nitrogen retention indicates onset of progressive renal impairment, consider withholding or discontinuing diuretic therapy.

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muscle spasm, weakness, restlessness. When severe adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSEAGE: Individualize dosage by titrating for maximum therapeutic response at the lowest possible dose. Hypertension: Initial—Usual dose 75 mg daily. Maintenance—After a week dosage may be adjusted downward to as little as 25 mg or upward to as much as 100 mg daily. Combined therapy: When necessary, other antihypertensives may be added gradually and with caution because of the potentiating effect of this drug. Dosages of ganglionic blockers should be halved.

Edema: Initial—25 to 100 mg daily or intermittently. Maintenance—25 to 100 mg daily or intermittently. Restrictive patients may require up to 200 mg daily.

SUPPLIED: Tablets, 50 mg (yellow, scored); bottles of 30, 60, 100, 1000 and Accu-pak blister units of 100, 1000 and 5000.

Tablets, 25 mg (pink, scored); bottles of 100, 1000 and 5000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company, Division of CIBA-GEIGY Corporation, Summit, New Jersey 07901

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The Only Independent Weekly Medical Newspaper in the U.S.

Medical Tribune

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Paranormal Studies

PUBLICATION of a paper on psychology in *Nature* does seem to cohere upon it the imprimatur of this august journal of science. And that was the reaction to it in the daily press and in TV news broadcasts. In a leading article in the same issue, *Nature* itself says that the appearance in the journal "is not a process of receiving a seal of approval from the establishment; rather it is the serving of notice on the community that there is something worthy of their attention and scrutiny."

In spite of reservations about the paper expressed in the leading article, what is worthy of attention and scrutiny is evidence from a series of experiments "suggesting the existence of one or more perceptual modalities through which individuals obtain information about their environment, although this information is not presented to any known sense." The article is entitled "Information transmission under conditions of sensory shielding"; its authors, R. Targ and H. Puthoff, are two physicists at the Electronics and Bioengineering Laboratory of the Stanford Research Institute. It is noteworthy that *Nature* published the article in the section of the Physical Sciences, not the Biological Sciences.

In any event, Targ and Puthoff seem to have confirmed that Uri Geller,

under controlled conditions that eliminated chicanery, has a remarkable ability to "reproduce target pictures drawn by experimenters located at remote locations" and that Pat Price has an equally remarkable ability to "describe randomly chosen geographical sites located several miles from the subject's position and demarcated by some appropriate means (remote viewing)."

In these days of excitement about acupuncture, why not parapsychological powers as well?

An anecdote by the late Dr. Claude S. Beck about his intern days at the Johns Hopkins University seems appropriate. Dr. Beck wrote: "Doctor Finney had Professor Halsted see a patient at the Union Protestant Infirmary. Surgical operation was done. Doctor Halsted's diagnosis was wrong. Doctor Finney's diagnosis was correct. The following comment was made, 'Finney, on what did you base your diagnosis?' Answer, 'Just a hunch, Professor.' Whereupon Halsted said, 'I would rather be wrong with reason than right without reason.' How could an intern interpret this? Was it the sublime in logic or was it the arrogance of being Professor?"

Many of us would rather be right with a hunch—no matter how paranormal it might be.

The Advantage of Being Female

THAT mortality statistics heavily favor the female over the male has been well publicized. As an editorial in this page put it four years ago, "Whatever inequalities exist socially and politically, biologically the deck is stacked against the male." The actual statistics are not, however, well known. The *Statistical Bulletin* of the Metropolitan Life in its August issue has compiled decennial figures from 1900-1970 for the sex ratio of female to male mortality by age group, based on data from the National Center for Health Statistics. For the year 1970, the leading causes of death are also listed.

Death rates for all ages among women from 1900 until 1920 were about 10 per cent lower than those among men. But although the rates have been declining for both sexes thereafter, the advantage to women has been steadily increasing. In 1930 the over-all female mortality was 84 per cent that of the

male; in 1940, 77 per cent; in 1950, 69 per cent; in 1960, 62 per cent and by 1970 it had fallen to 57 per cent. As the *Bulletin* states, "At ages under 5 and at ages 85 and over the sex differential has changed little since 1900, but in all other age groups the female advantage has continued to grow. In 1970 female mortality was 36 per cent of that for males at ages 15-24 and ranged between 47 and 57 per cent of that for males at ages 25 to 74."

This advantage cannot be attributed to "the considerably higher death rates from accidental injuries and violence to which men are subject." Even when these deaths are excluded, women's mortality is more favorable. A variety of explanations have been proffered for the lower death rates among women but the most likely one appears to be the presence of a biological factor, whatever that might turn out to be.

Intestinal Parasites in Children

CLINICAL QUOTE: "Infection with intestinal parasites... can be with a variety of organisms. It can cause a variety of medical, public health and perhaps even social problems. Some of the medical problems may be considered serious, some merely troublesome. By serious, we mean such clinical manifestations as anemia, pneumonia, perforated bowel, op-

pendicitis, bloody or mucous diarrhea, and growth failure.

"Anyone who has been associated with school health programs... has most likely had the experience of the angry telephone call... from the frustrated mother who reports that her child 'has picked up pinworms at school.'" (Dr. Vivian K. Harlin; see page 1.)



"Swigler? Not the Swigler of 'A Reappraisal of Imipramine Levels in Primary Depressive Syndromes?'"

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LETTERS TO TRIBUNE

Blood Lead Studies

The article (MT, Sept. 25) comparing two apparently conflicting studies dealing with blood lead levels in El Paso, Texas, touches on an important area, and needs to be clarified. Dr. McNeil reported the details of a study involving children living near a lead smelter and their matched controls at the Symposium on Recent Advances in the Assessment of the Health Effects of Environmental Pollution in Paris. Dr. Carnow's observations were based on anecdotal information that he collected and did not constitute data that could be compared to the McNeil study.

Dr. McNeil's study included 138 of the total of 206 children that lived in the Smeltertown area. They were carefully matched with controls, and when the two groups were compared, there were very few and insignificant instances of deleterious effects noted in either group. Of the children living in Smeltertown that did not participate in the McNeil study, 51 per cent had blood lead levels exceeding 40 mcg per 100 ml, whereas 73 per cent of those in the study exceeded that level. Therefore, it seems highly unlikely that those children not included in his study would have symptoms attributable to lead effects as Dr. Carnow suggests. The question of subtle neurophysiologic effects occurring secondary to asymptomatic elevations of blood lead can only be answered by collecting data from carefully controlled studies.

BOWARO B. MCCABE, M.D.
Madison, Wis.

fornia psychologist? I believe that medical publications should lead the way in making sure the credentials of the "Dr's about whom they are writing are clear.

MEDICAL DOCTOR

(Dr. Paul E. Keith is a physician. MEDICAL TRIBUNE uses "Dr." before the full name to refer to a physician. A Ph.D. is so designated in the first reference. Thereafter he is also "Dr."—Ed.)

'Hard Evidence' Boys

I very much appreciated your editorial, "Apologies Are in Order from the Double Blind Boys to the Practicing Physician" (MT, Sept. 25). I think it is time too that somebody examined the "hard evidence boys." Lately I have wondered about the "hard evidence" on the basis of which patients with diverticulosis were put on a low roughage diet; the hard evidence on the basis of which patients with coronaries were kept in bed for 6 weeks; the hard evidence on the basis of which obese, maturity-onset diabetics were treated with insulin-stimulating drugs; the hard evidence on the basis of which people with TB were put to bed for a year; and so on.

History will in all probability show that "double blind" really demonstrates that the investigator's hindsight was as bad as his foresight.

SAMUEL J. ARNOLD, M.D.
Morristown, N.J.

Political Diagnosis?

Thank you for your refreshing article on "Complications of Phlebitis" which is a critique of Dr. Walter Tkach's, also General Tkach's, diagnosis of former President Nixon's phlebitis. I think you made it clear, though you didn't state so openly, that this was a political, not a medical diagnosis and was for the purpose of furthering Mr. Nixon's previous stance against revealing all that festered in his administration.

I have seen no medical criticism of Dr. Tkach's statements and your analysis is one indicator of why there needs to be Peer Review as well as community enrollment with regard to health care.

HARRY E. BELLER, M.D.
Miami, Fla.

100% Agreement

Now Dr. Sackler's done it... written an editorial with which I can agree 100 per cent—"TEARS ALONE ARE NOT ENOUGH".

T. NORLEY, M.D.
W. Palm Beach, Fla.

The Nude Centerfold MD

I am a steady reader of yours... After reading your current (Oct. 9 issue) today, I have elected you to kick off my new campaign: that all publication which use the abbreviation Dr. shall stipulate whether he (or she, of course) be MD or some other.

Is "Dr." Keith, of the *Playgirl* centerfold, an MD or a non-upright California psychologist?



What a difference a day can make

Your counsel and reassurance—and Ritalin.
A logical first step in treating mild depression* and often all that's needed to bring quick symptomatic relief.
Indeed, your patient may be-

gin to feel better within hours—her spirits boosted, her mood brightened. A single prescription may be all that's needed.

Ritalin is usually well tolerated even by older or convalescent patients. Note, however,

that it is not indicated in the more severe depressions.
But whenever depression is mild, think of Ritalin—so your patient has a better chance of waking up to a brighter tomorrow.

Ritalin
(methylphenidate)
acts quickly to relieve symptoms
in mild depression

*This drug has been evaluated as possibly effective for this indication. See brief prescribing information.

Ritalin® hydrochloride
(methylphenidate hydrochloride)
TABLETS

INDICATION
Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indication as:
"Possibly" effective: Mild depression.
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to this drug and in patients with glaucoma.

WARNINGS
Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (ie, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued. Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.

Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenytoin, phenobarbital, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustment of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy
Anatomic animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.
Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with concurrent abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overuse can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an abnormal heart rhythm may react adversely; therefore, ECG monitoring is necessary. Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, anaphylaxis, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSEAGE AND ADMINISTRATION
Adults
Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response.

Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. The low patient who is unable to sleep if medication is taken late in the day should take the last dose before 8 p.m.

HOW SUPPLIED
Tablets, 20 mg (pale green, scored); bottles of 100 and 1000.

Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.

Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

11-11111 C I B A

Wednesday, November 20, 1974

MEDICAL TRIBUNE

13

New Stereotactic Biopsy of Breast Avoids Disfigurement

Continued from page 1

in wondering if the cure may not be worse than the disease, at least for the 67 per cent of women biopsied who are proved not to have cancer," he declared.

Dr. Schwartz, who is Associate Professor of Surgery at Jefferson, said that the key to the new biopsy procedure is the stereotactic placement of needles as surgical markers for the lesions, prior to excision.

On the day scheduled for biopsy the patient receives repeat mammography in order again to locate the suspicious lesion. Its distance from the nipple is carefully measured on both the cranio-caudal and lateral x-rays, and under local anesthesia, a 22-gauge 1.5-inch needle is placed in the breast and directed toward the expected site of the lesion. The x-rays are repeated to identify the needle's exact position in relation to the lesion.

Needle Within 1 Cm. of Lesion

"If the tip of the needle is within one cm. of the lesion, it is fixed in place with adhesive tape and the patient is sent to the operating room," Dr. Schwartz said. "If the needle is more than 1 cm. from the lesion, a second needle is placed in the breast, using the first needle as guide, and the films are again repeated."

"In the operating room, under general anesthesia, a circumareolar incision is outlined with its center in the line of the needle. . . . If the suspicious area is minute, we usually excise about 1 cc. of tissue at the tip of the needle; when a larger area is seen on the x-ray, an appropriate sized piece of tissue is excised."

The specimen is then x-rayed and the picture developed within 90 seconds to make sure that the lesions have been excised, "with a very minimum of contiguous normal breast tissue, leaving the patient with an acceptable cosmetic result."

In 30 cases, Dr. Schwartz reported, "we have not yet missed the suspicious area."

The patient is discharged the following day, after the pathologist has embedded and sliced the entire section, and made his diagnosis.

Patients 'Less Anxious'

"We may thus give the patient the good news at the time she goes home. If the lesion is benign, or discuss the finding with her before discharge when malignancy is encountered," the surgeon stated. "Using this technique, we have noted our patients are less anxious when biopsy is recommended, because they are sure of a minimal operation, with a short hospital stay. No patient, subsequently discovered to have benign disease, has been sorry she underwent the operation, since no disfigurement has resulted. Patient acceptance has been universally excellent."

Turning to the problem of radical mastectomy, Dr. Schwartz again chided surgeons for performing operations that "do not have to be any more morbid or disabling than simple or total mastectomy."

Loss of the pectoral muscles need not be poorly tolerated, he declared, nor need radical mastectomy result in



A postoperative photo shows excellent cosmetic result following a biopsy on patient's right breast with Dr. Schwartz's procedure. Below, under local anesthesia, the breast is positioned on the x-ray plate and a 1.5-inch needle is directed toward the expected site of the lesion as a marker.



loss of motion of the ipsilateral arm.

"My patients may postoperatively look forward to participating in any activity they performed prior to surgery—golf, tennis, or bowling."

To illustrate his point at a news conference, Dr. Schwartz showed a photograph of a 75-year-old patient who had undergone a right radical mastectomy, including loss of the pectoral muscle. He noted the cosmetic

excellence of the result, and added:

"This patient can do anything with her right arm except throw a forward pass. But then how many of our patients are quarterbacks?"

Coauthors were Drs. John D. Wallace, Research Professor of Radiology; Herman Libshitz, now at Duke University; and Gerald Dodd, now at M.D. Anderson Hospital and Tumor Institute, Houston, Tex.



While the patient is under general anesthesia, a circumareolar incision is outlined with its center between the nipple and the line of the needle. The needle has been stereotactically positioned as a surgical marker for the lesion.

Counselor Role With Married Patients Urged

Continued from page 3

clinging attitudes on sex, what kind of life style they foresee, etc. They should also decide how to handle such "trivial" items as who takes out the garbage, who pays the bills and handles the credit cards, which in-laws look like trouble and where the couple will spend Christmas.

Other hard questions should force the couples to ask themselves if the marriage breaks up who will take care of the children.

"In a great number of troubled marriages, you can almost be sure that it was a pretty bad marriage to begin with, so that the family physician should do what he can to prevent a mismatch when he can."

Should Get Both Sides

If possible, he continued, the physician should talk to both partners in a troubled marriage at the same time, although he may also find that he must talk to each partner separately to find out what is the real root of the problem. In all cases, however, he should get both sides of the story.

"Sometimes you find out that when a husband says his wife is no good in bed, or vice versa, it's because they spend so much time fighting outside the bed."

If a marriage has become dull, Dr. Mead suggested that the physician should encourage the troubled couple to find out what has to be changed to make the marriage lively and interesting again.

"Ask them," he suggested, "what can you do to make this marriage better? If you want to change your spouse first think of what you might do to change yourself."

"Marriages, like people, can develop bad habits," Dr. Mead concluded. "And, as with personal bad habits, each couple should have the power and flexibility to change the habits that have altered the previously happy pattern of their marriage."



To assure adequate outpatient care, Dr. Gordon went on, hospitals should be paid on a capitation basis, rather than per per cent of occupancy. And finally, he hopes that Federal funds will become available to states like Florida for the care of mentally ill out-of-staters who come down out of orbit in their territories.



C I B A

School Pinworm Screening Drives Urged

Continued from page 1

"Our awareness of these diseases has declined and surveillance has become negligible," Dr. Crowder declared, adding that a current rise in "hand-to-mouth" infections may have been significantly influenced by social changes.

Among these, she cited an increase in population, with crowded living conditions that contribute to inadequate disposal of solid wastes; and poverty, with accompanying malnutrition and exposure to environmental health hazards.

But one school innovation—wall-to-wall carpeting in classrooms—has also played a part, Dr. Crowder believes. The carpeting provides "excellent opportunities" for transmission of pinworm ova, and promotes transma-

sion of scabies and pediculosis as well.

Dr. Crowder warned, too, that the generally beneficial custom of serving between-meal snacks at school will contribute to infection statistics unless there is adequate handwashing.

Physicians and educators concerned with child health were urged by Dr. Crowder to look into the situation at their local schools and see if programs exist to screen children for intestinal parasites. Data should be gathered on morbidity reports from the city or county health department, the incidence of such infections found by physicians in private practice, and the kinds of physical exams—if any—that are required by the school.

Dr. Howard B. Shookhoff, who heads the division of tropical diseases

in New York City's health department, outlined the methods of treatment now recommended for six intestinal parasite infections.

● **Pinworm:** "The drug of choice at this time is pyrantel pamoate." Both it and pyriminium pamoate are effective in a single dose, he said, but the former has the advantages of a lower frequency of nausea and a white (rather than a red) color. Some population groups object to red medication because it resembles blood, he noted.

● **Ascaris lumbricoides** (common roundworm): Piperazine has been the treatment of choice, Dr. Shookhoff commented. However, he now has the "distinct impression" that pyrantel pamoate is more effective.

● **Hookworm:** For moderate or heavy

infections, "the most effective drug in our experience is tetrachloroethylene," given in a single dose on an empty stomach. Any anemia should be corrected before the drug is used.

The new agent, mebendazole, may be more satisfactory and less toxic, Dr. Shookhoff said.

● **Trichurias trichiura:** Mebendazole has been introduced primarily for the treatment of this infection, "for which we have until recently had no satisfactory oral medication."

● **Strongyloides stercoralis:** Thiabendazole is recommended, with pyriminium pamoate as an "alternative treatment." Both are used in a suspension.

● **Trichinella spiralis:** In severe cases, treatment of choice is "the nonspecific use of steroids." Some specialists advise treatment with thiabendazole in addition, Dr. Shookhoff said.

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Tenuate[®]
(diethylpropion
hydrochloride N.F.)

BRIEF SUMMARY: Tenuate is indicated in the management of excessive obesity as a short-term adjunct (a few weeks) to a regimen of weight reduction based on calorie restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hypertension, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glucose.

Warnings: Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, hypertensive crisis may result.

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There are occasional reports of subjects dependent on amphetamine later chronically abusing diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunctioning which, in the patients who have increased the desire to many times that recommended, abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with amphetamine include severe headaches, irritability, tremor, anorexia, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

Use in Pregnancy: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks.

Use in Children: Tenuate is not recommended for use in children under 12 years of age.

Precautions: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension.

Insulin requirements in diabetic patients may be altered in association with the use of Tenuate and the concomitant dietary regimen.

Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or discontinued at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmias. One published report described 7-mm changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride.

Central Nervous System: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, headache; rarely, hypomania episodes at recommended doses. In a few subjects an increase in convulsive episodes has been reported.

Gastrointestinal: Dryness of the mouth, unpleasant taste; nausea, vomiting, abdominal discomfort, diarrhea, constipation, flatulence, epigastric discomfort.

Allergic: Urticaria, rash, eczematous, erythema.

Endocrine: Impotence, changes in libido, menstrual upset.

Electrocardiographic: Some marked depression, arrhythmias, tachycardia.

Miscellaneous: A variety of idiosyncratic adverse reactions have been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dizziness, and polyuria.

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Division of Richardson-Merrell Inc.
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(diethylpropion
hydrochloride
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Merrell

Rauwolfia Studies Faulted for Methodology at FDA Meeting

Continued from page 1

1972 and produced the "entirely unexpected" and therefore "unhinged" finding that women given rauwolfia alkaloids—principally reserpine—to control hypertension had a more than threefold greater risk of breast cancer than women who had not taken the drug. The English and Finnish studies were prompted by the finding in Boston and produced similar results.

Following reviews of the three investigations by representatives of the three study teams—Drs. Hershel Jick, Samuel Shapiro, and Bruce Armstrong, of the Boston, Helsinki, and Bristol groups, respectively—areas of possible bias were pointed out by NIH, FDA, and independent investigators.

The four "major deficiencies" in the studies, in the eyes of the National Heart and Lung Institute, were their possibly differential ascertainment of exposure to rauwolfia alkaloids, the possibility that their results reflected extraneous confounding factors such as previous hypertension that might influence rates of exposure to the drugs, difficulty in establishing an adequate time sequence between the suppressor cause and its effect, and the validity of the exclusions used in establishing control groups, said Dr. Munnig Feinlich, chief of NHLI's epidemiology branch.

Some Controls Excluded

In the Boston study, he noted, about 45 per cent of possible hypertensive controls were excluded because their previous medication was unknown—"a serious shortcoming since proper allocation of the unknown group could possibly alter the study's major findings." He also noted that about half the breast cancer patients in the Boston study had been taking reserpine for less than five years, which he called "a surprisingly short interval if the drug is indeed carcinogenic."

"More reliable data on duration of treatment must be obtained before any statement of 'causality' can be made," he said.

Robert T. O'Neill, Ph.D., an FDA statistician, commented that the three studies dealt minimally with the relationship between age, duration of reserpine use, and the occurrence of breast cancer.

"The data in the three studies may not be able to answer this question, which certainly is of relevance in determining the subpopulation of women at the greatest risk," he said. "When considering hypertensive women alone, the data in the Boston study indicate a significant risk of breast cancer associated with reserpine use as compared with the use of other antihypertensive agents. The Finnish study appears to give no such evidence. The English study, with other neoplasms not excluded, is suggestive of an increased risk."

Questions requiring further study, he said, are the adequacy of the control groups as representatives of the hypertensive population and of users of reserpine and other antihypertensive agents; the relationship between duration of use, age, and increased risk of breast cancer; the influence that users of "undetermined" antihypertensive

drugs may have had on the studies' results; case and control exclusion criteria; and the adequacy of case and control selection in the three investigations.

Dr. Norman M. Kaplan, a representative of the American Heart Association, urged that reserpine and other rauwolfia derivatives should not yet be restricted and that additional studies be undertaken to provide more definitive evidence about their carcinogenic potential.

Not only are the three studies of reserpine methodologically wanting, but "the abrupt removal of its use may put millions of hypertensives at increased risk of cardiovascular catastrophe," said Dr. Kaplan, a Professor of Internal Medicine at the Texas

Southwestern Medical School, Dallas. He found four basic faults with the studies:

'Spuriously Low Exposure'

● "The control populations almost certainly had a spuriously low exposure to reserpine. In the Boston study, all patients with any cardiovascular disease were excluded, thereby removing most of the potential reserpine users. In the English study, only 0.43 percent of the controls had exposure to reserpine. Based upon crude estimates that 33 percent of women over 50 have hypertension and that one-fourth of these are on antihypertensive therapy and, in turn, one-fourth of these are on reserpine, the exposure should be 2 percent."

● All three studies were retrospective.

● "There was unevenness in the matching of users and nonusers in the 50- to 59-year age groups of the Boston series and a decreased proportion of such patients in the Finnish series."

● "Two potentially important risk factors for both hypertension plus reserpine use and carcinoma of the breast were not taken into account, namely, body weight and parity."

Dr. Howard D. Cohn, vice-president of the CIBA-Geigy Corporation, reserpine's principal manufacturer, and medical director of the company's pharmaceuticals division, criticized the studies for their use of the relative risk concept and also disputed the applicability of their results to the general population.

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Past-operative... recent surgery... still confined to bed... or restricted ambulation...

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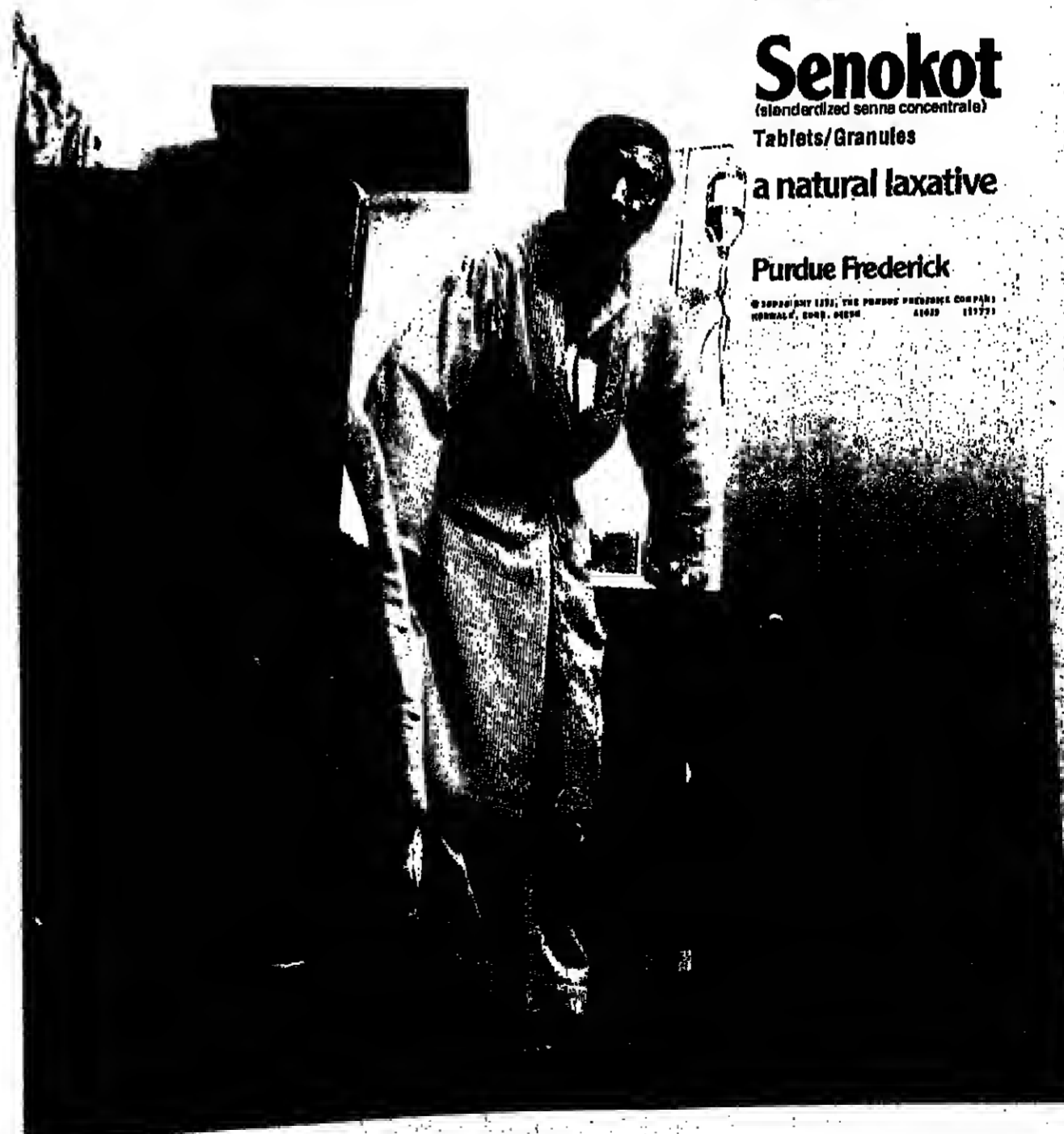
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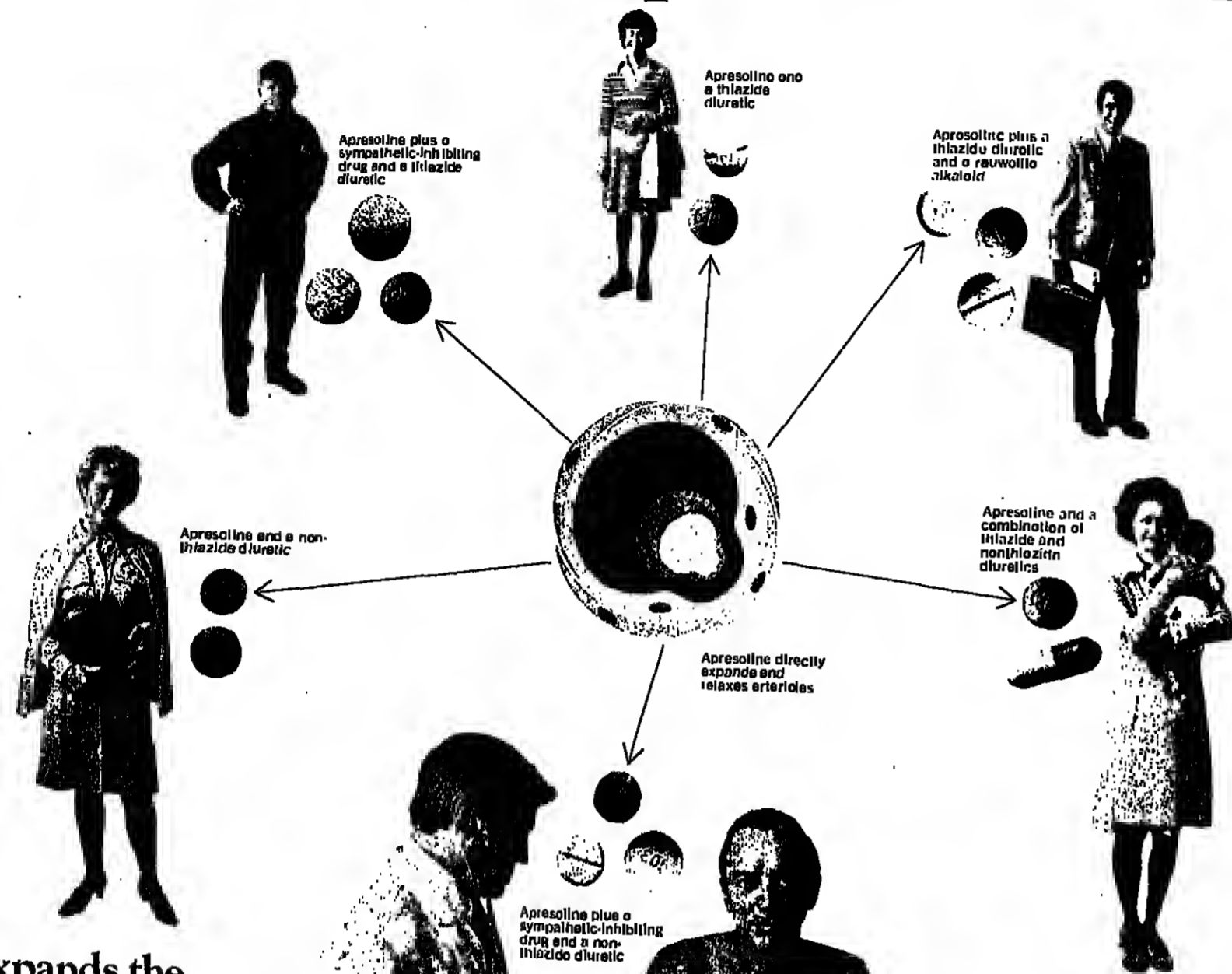
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Apresoline...expands the possibilities (hydralazine) in blood pressure control



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An unusually versatile antihypertensive agent, Apresoline can be combined with almost any antihypertensive regimen—thiazide or nonthiazide diuretics, sympathic-inhibiting drugs or rauwolfia alkaloids. The greater latitude of choice increases your options for choosing an appropriate therapy.

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An antihypertensive unique in its mode of action, Apresoline works like no other oral agent. It directly relaxes the smooth muscle of arterioles, thus decreasing peripheral resistance. There is an accompanying increase in cardiac output and rate. The pressure comes down.

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TABLETS
Essential hypertension, alone or as an adjunct.
CONTRAINDICATIONS
Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.
WARNINGS
Chronic administration of doses over 400 mg per day may produce an arrhythmia-like syndrome leading to a clinical picture simulating acute systemic lupus erythematosus. This may also occur in lower doses. Most of these reactions are reversible upon withdrawal of therapy, but long-term treatment with steroids may be necessary and residual blood counts, L.E. cell preparations and antinuclear antibody titer determinations are indicated before and periodically during prolonged therapy, even though patient is asymptomatic. These studies are also indicated in the presence of any unexplained symptoms.

Use MAO inhibitors with caution.

The drug should be used only when, in the judgment of the physician, it is deemed essential to the patient.
PRECAUTIONS
Use cautiously in suspected coronary artery or other cardiovascular diseases, cerebral vascular accidents, and advanced renal disease. Postural hypotension may occur, and the pressor response to epinephrine may be reduced. Peripheral neuritis, evidenced by numbness, tingling, and pain, has been reported. Published evidence suggests an antihypertensive effect in patients with peripheral vascular disease. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. Periodic blood counts are advised during prolonged therapy.
ADVERSE REACTIONS
Common: Headache, palpitation, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

In a few resistant patients, up to 300 mg Apresoline daily may be required for a significant antihypertensive effect. In such cases, a lower dosage of Apresoline combined with a thiazide, reserpine, or both may be considered. However, when combination therapy, individual titration is essential to insure the lowest possible therapeutic dose of each drug.
HOW SUPPLIED
Tablets, 10 mg (pale yellow, dry-coated); bottles of 100 and 1000.
Tablets, 25 mg (pale yellow, dry-coated); bottles of 100, 500, and 1000.
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Tablets, 100 mg (pale yellow, dry-coated); bottles of 100.
Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

C I B A

Wednesday, November 20, 1974

MEDICAL TRIBUNE

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Tribune Economic Analysis



Helping the Stock Market's Investors

BY ELIOT JANEWAY
Consulting Economist

The stock market has now been hurt so badly and is hurting so many people that remedial measures are becoming nearly as practical as public service jobs for the unemployed. The bill introduced by Sen. Lloyd Bentsen

(D-Tex.) points the way to help the stock market. But although Sen. Bentsen has been a voice in the wilderness on the subject, it does not go far enough. The Bentsen Bill calls for liberalizing the long-standing taxpayer's right to deduct \$1,000 a year of market losses from taxable income by increasing the deductible limit to \$4,000. The rationale is that everything else has quadrupled since this deduction was legalized.

The theory is fine, but putting it into practice on the scale of \$4,000 per taxpayer, with losses per year, will not help them or the market or the situation. The way to bring first aid to everyone wounded in and dependent upon the stock market is to liberalize the ceiling to a meaningful amount—or, better still, to take the ceiling off

altogether—subject to conditions that will protect the public interest, bring relief to victims of the storm and pump life back into the market.

Attaching two such conditions to this liberalized loss-taking would help revitalize the Treasury as well as the market. The first is similar to the deferral privilege given homeowners who take a profit setting and then reinvest in a new home. It would require reinvestment within six months in securities paying interest or dividends taxable as ordinary income. The other would require some reasonable but meaningful portion of the reinvested proceeds of loss-taking to go into non-negotiable U.S. Treasury securities, which would pay interest taxable as ordinary income.

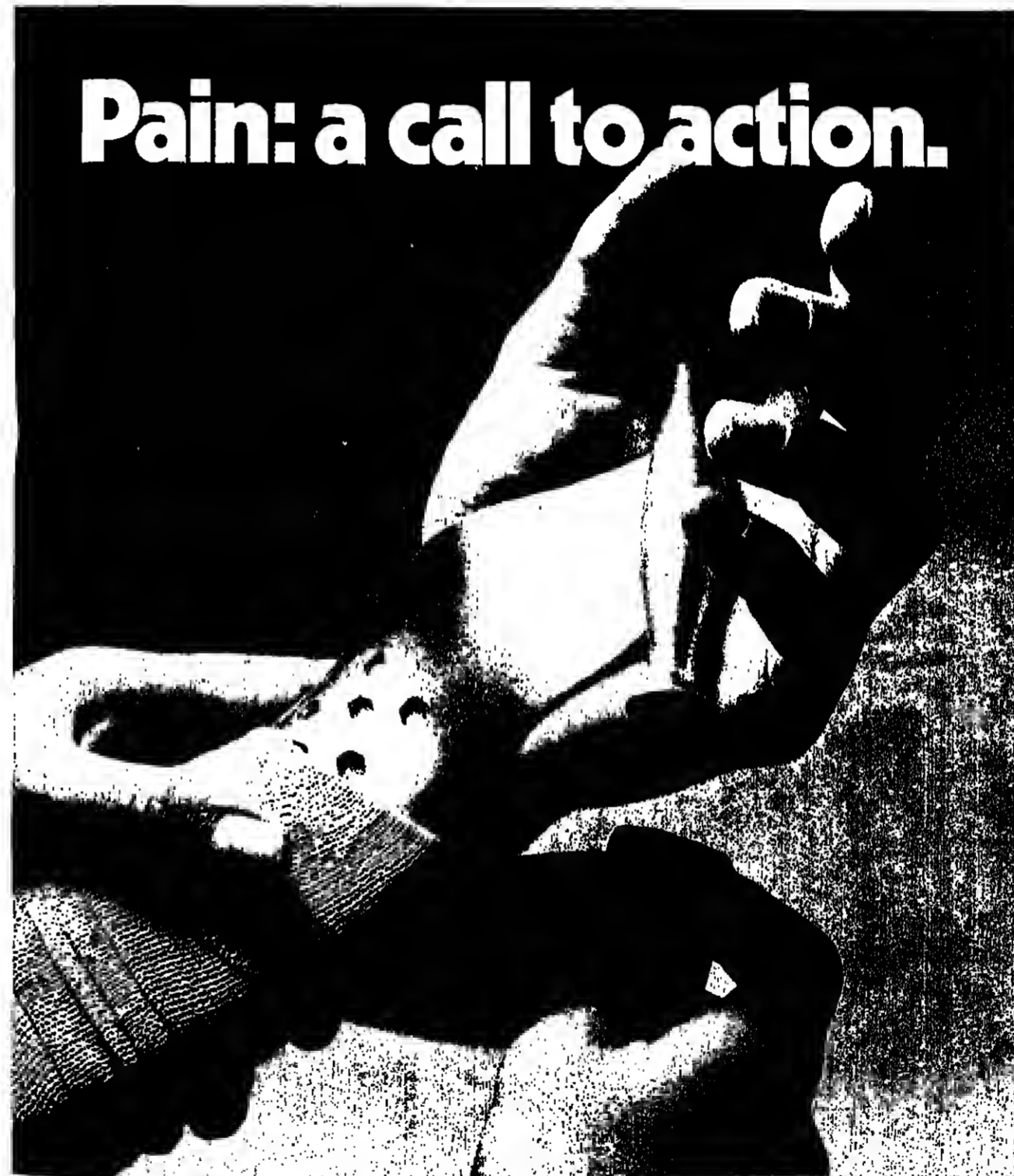
There's no shortcut to beating in-

flation except for taxpayers to have an incentive to buy and hold Treasury securities for a period of years.

With all your harping on liquidity, you seem to write only for the fat cats. I'm a young physician, just starting out. These high interest rate investors are starving me. Where can I borrow money cheaply?

Young M.D., New Jersey

Absolutely nowhere. That's the cause of the trouble! The banks and the fat-cat retailers are making more money lending on small loans than on anything else—twice the prime rate. Your only recourse is to try to put aside a little cash and use the buying power it will give you as a bargaining lever. Remember: those trying to sell you are apt to need cash even more than you.



Pain: a call to action.

Whenever an APC/narcotic is indicated.

Percodan®

Each yellow, scored tablet contains 450 mg. oxycodone HCl (Warning: May be habit forming), 0.30 mg. aspirin, 100 mg. phenacetin, and 32 mg. caffeine.

INDICATIONS: For treatment of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

WARNINGS: Drug Dependence: Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Physical dependence, chemical dependence and tolerance may develop upon repeated administration of Percodan, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing preparations. In addition, specific contraindications, Percodan is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients: Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using Percodan should be cautioned accordingly.

Interaction with other central nervous system depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with Percodan may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy: Safe use in pregnancy has not been established relating to possible adverse effects on fetal development. Therefore, Percodan should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children: Percodan should not be administered to children. Subletting should be avoided with caution in the presence of pediatric use or congenital abnormalities.

PRECAUTIONS: Read label and insert carefully. The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be suitably expected in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce a decrease in ventilation which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Percodan to other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special test patients: Percodan should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urinary tract obstruction.

Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

ADVERSE REACTIONS: The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. Some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation and pruritus.

DOSE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in case of more severe pain or in those patients who have become tolerant to the analgesic effect of Percodan. The usual adult dose is one tablet every 4 hours as needed for pain.

CAUTION: INTERACTIONS: The CNS depressant effects of Percodan may be additive with other CNS depressants. See WARNINGS.

Aspirin may enhance the effect of anticoagulants and inhibit the effect of uric acid excretion.

MANAGEMENT OF OVERDOSE: Signs and Symptoms: Serious overdose with Percodan is characterized by respiratory depression, extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes hypotension and hypothermia. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur. The ingestion of very large amounts of Percodan may, in addition, result in acute mydriatic intoxication.

Resuscitation: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist, naloxone, is effective in reversing respiratory depression. In severe overdosage, resuscitation should be continued until adequate respiration is established. Since the duration of action of oxycodone may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.

An antagonist should not be administered in the absence of directly significant respiratory or circulatory depression.

Drowsiness, dizziness, headache, constipation and other supportive measures should be employed as indicated.

Consult complete literature before prescribing.

Percodan® Tablets

Each yellow, scored tablet contains 450 mg. oxycodone HCl (Warning: May be habit forming), 0.30 mg. aspirin, 100 mg. phenacetin, and 32 mg. caffeine.

See facing page for Brief Summary

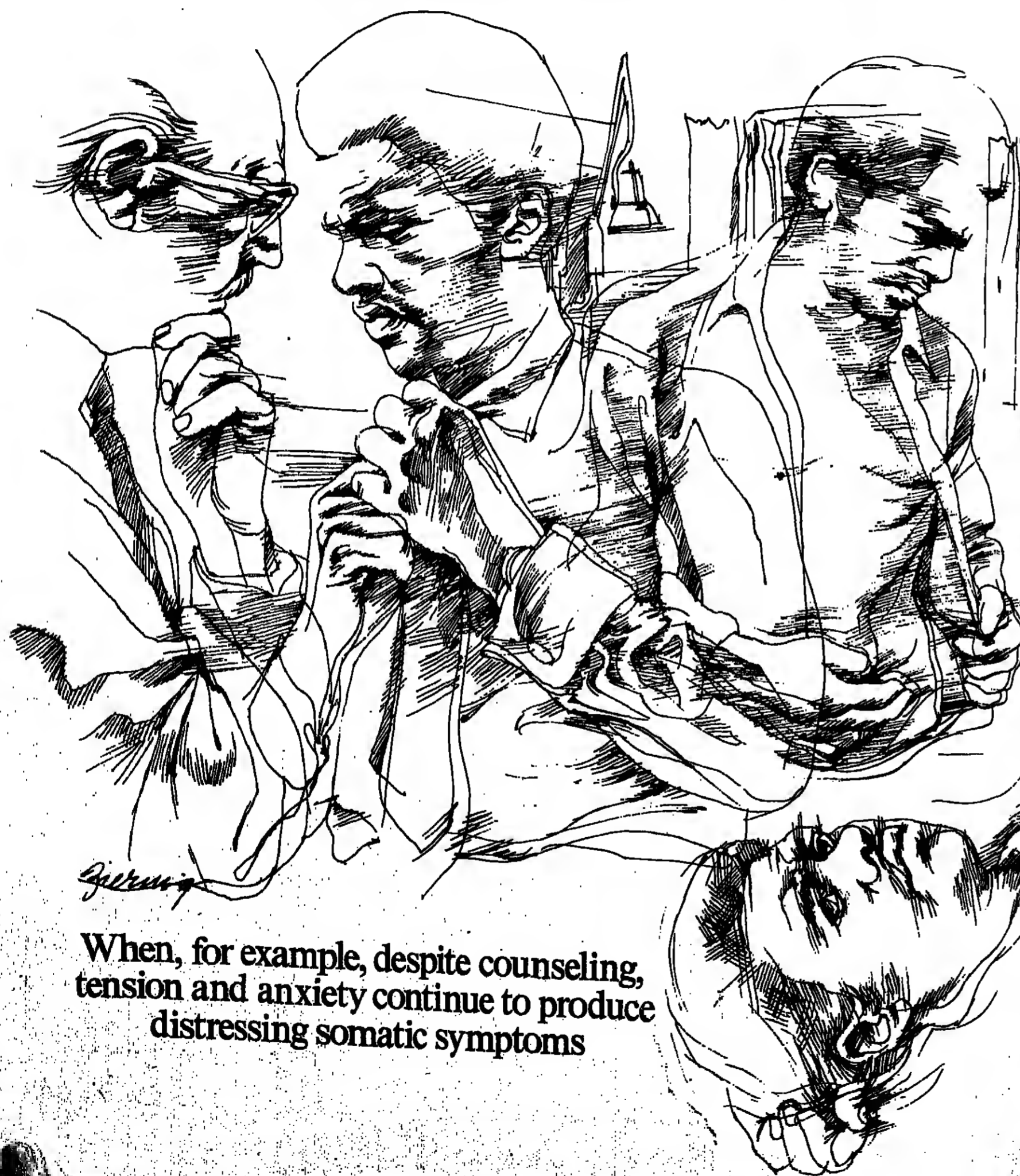
*See dosage and administration section of Brief Summary

- rapid acting
- effective, reliable oral analgesia in moderate to moderately severe pain
- oxycodone, the principal ingredient of Percodan, is one of the more readily absorbed oral narcotic analgesics
- one tablet q. 4 h.*

Whenever an APC/narcotic is indicated.

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If there's good reason
to prescribe
for psychic tension...



When, for example, despite counseling,
tension and anxiety continue to produce
distressing somatic symptoms

Prompt action
is a good reason
to consider Valium[®]
(diazepam)



When your patient's somatic complaints are associated with tension and anxiety and you have tried counseling and other supportive measures alone, you may decide to prescribe psychotherapeutic medication. If you do, the question remains: which one?

Valium (diazepam) is one to consider closely. One that works promptly as an adjunct to continued supportive measures. One that generally produces significant improvement within the first few days of therapy, although some patients may require more time for a clearcut response.

Prompt action. One good reason to consider Valium.

And should you choose to prescribe Valium, you should also keep this information in mind. Valium is usually well tolerated. Patients taking Valium should be cautioned against operating dangerous machinery or driving. Therapy with Valium should normally be continued until the patient's psychic tension symptoms have been reduced to tolerable levels.

Please turn page for a summary of product information.

Valium[®] ROCHE
(diazepam)

2-mg, 5-mg, 10-mg tablets

Valium® (diazepam)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed.

drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 100.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Clinical Trials



by Oldden

TRIBUNE SPORTS REPORT

Middle-Aged Fitness Fans Warned About Jogger's Heel

Medical Tribune Reports

NEW YORK—Jogger's heel—the latest side effect of the fitness craze—continues to pop up in radiologic and orthopedic practice, a leading radiologist reported here.

Warning "gung-ho nonathletes" to take it easy, Dr. Toni W. Staple of St. Louis said radiologists are seeing examples of painful heel calcification in the overzealous middle-aged male jogger, as well as in out-of-practice young athletes.

He explains that "jogger's heel" results from the repeated stress of flat-footed trotting, and appears on the x-ray as a "cloud of density in the heel. It stems either from compression of bone or the laying down of new bone."

Dr. Staple, who is Professor of Radiology at Mallinckrodt Institute of Radiology, Washington University, told

a Medical X-Ray Forum for Science Writers: "You see jogger's heel in the 40-year-old guy who is gung-ho and planning to get back into shape or in the young guy who has done nothing all winter and wants to impress the coach at the spring training turnout."

He commented that the majority of what are called athletic injuries are seen in amateurs or in nonathletes, rather than in professional athletes. "I suggest that such injuries should not be called athletic injuries, but injuries from participation in athletics," he said.

Dr. Staple estimated that approximately 40 per cent of the most common stress fractures occur in the heel, another 40 per cent in the forearm, and the remaining 20 per cent in other portions of the skeleton.

The X-Ray Forum was sponsored by the American College of Radiology.



A normal heel (upper x-ray) compared with a "jogger's heel," showing either compression of the bone or the laying down of new bone.

IMMATERIA MEDICA

By DUDLEY STRAUS

Odds and Ends

● Ethnic note: we see, in an HEW release, that the Navy Alcohol Abuse Control Program is referred to as the AACP.

● The First Heart Transplant Symposium and Workshop was held in Hot Springs, Ark., and featured "a comprehensive series of lectures and panel discussions, and a workshop with cadaver heads," we learn from a recent release.

● New Scientist reports that the Toronto Star reports that a Pompano Beach, Fla., man has developed a talking tombstone that also shows moving pictures of the deceased. No popcorn machine, as far as we know.

● "Washington (UPI)—The House today came within six votes of settling an eight-year-old fight of what to do about the crumbling west wall of the Capitol Building, and agreed to put off a decision for another two years."

—United Press International wire service.

And that's where we are these days.

● "... and assuming that it requires an average of one pack [of cigarettes] a day for 20 years (146,000 'cotton nalls') for an individual to develop lung carcinoma..."

—Minnesota Medicine.

Wait till you start coping with the metric system!

● "An HEW study of the biologic and behavior changes of age indicates the aged demonstrate 'great reserves of energy, intellect, and enthusiasm' in adapting to circumstances."

—release from the National Institute of Mental Health.

Now if you'll just name some circumstances...

● Dr. Milton H. Erickson of Phoenix found an old friend in a new form in the Phoenix Gazette:

"Abdominal fascialons always can be seen, although in some instances they can be concealed by the public hair-line."

Muscle Relaxation Credited to Acupuncture

By PATRICIA McBRID

Special Tribune Correspondent

PHILADELPHIA—One effect of acupuncture may be to relax chronically tense muscles, according to preliminary observations by a psychiatrist at the University of Pennsylvania School of Dental Medicine.

With an electromyograph, Dr. Arnold H. Gessel has recorded substantial declines in muscle tension at the site of pain in two patients after acupuncture. The decreased tension—in muscles tight to the point of spasm—compared with the best results of biofeedback control, said Dr. Gessel, a specialist in biofeedback and relaxation therapies.

Dr. Gessel conceded that two cases were a very small series, but said that since the changes seen were profound and clearly linked in time to the acupuncture treatments, and an investigation should be undertaken into the relationship between acupuncture and muscle relaxation.

"I think muscular relaxation could explain some of the reported effects of acupuncture," said Dr. Gessel. "This has all the earmarks of a real phenomenon."

Dr. Gessel also tested muscle tension in six other acupuncture patients, all but one of whom showed decreased contraction rates after the twenty-minute needling session. Contraction rates declined from moderately elevated to normal during and after the acupuncture.

Most of the patients in the study had a diagnosis of arthritis, with pains in the back, hip, shoulder or legs.

2 Cases Described

In a report to the World Acupuncture Conference in Philadelphia, sponsored by the University of Pennsylvania, Dr. Gessel described one of his two cases as that of a 50-year-old woman with pain and numbness of the right shoulder and arm. The right trapezius muscle was extremely tight, with spasmodic levels of contraction—about 180 microvolts—before acupuncture, despite ten minutes of relaxation prior to treatment. Normal EMG readings, Dr. Gessel said should have been about 15 microvolts.

When the needles were placed, readings on the trapezius declined to 50 microvolts and by the end of the acupuncture session, they were at 10

microvolts. The same phenomenon occurred at the second acupuncture session. On the third occasion, the woman said she was feeling better. That day, for the first time, muscle tension in her shoulder read 80 microvolts rather than 100, before treatment.

Dr. Gessel speculated that acupuncture over time may have "retrained" the muscle to lower rates of contraction. He did not know why needles should have such an effect, especially since they were not placed in the muscle itself, but in traditional acupuncture points aimed at shoulder pain.

In the second case, a fifty-year-old man was treated for pain in his calf, which he said was due to phlebitis. Dr. Gessel's electrodes picked up tension readings of 400 microvolts on the gastrocnemius muscle in the calf (compared to normal readings of about 25 microvolts in the relaxed state).

After acupuncture, EMG readings dropped to 150 microvolts. Clalcal improvement is as yet undetermined, Dr. Gessel said.